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SOCIAL SECURITY

Report on the implementation of the social security finance acts

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Chapter IV

Ten years of evolution in healthcare systems and healthcare payment systems in Europe: profound changes and learnings for healthcare system reform in France

OVERVIEW

Current health expenditures in the countries of the European Union reached 10.5% of their GDP and the sector thus funded employs 27.5 million people1. The level of public spending devoted to these policies – which often exceed 15% of the total – is, moreover, one of the most significant variables in balancing government budgets. Thus, the issues relating to healthcare system reform have taken on urgency throughout the Union.

Over the last 10 years, these systems have been subjected to various pressures that have weakened their financial balance.

First, they were abruptly confronted with the economic and financial crisis in 2008-2009, followed by a major public finance crisis. In most countries, the latter required savings plans, as well as large-scale structural reforms, the terms of which varied.

Over the long term, they have to contend, to a growing extent over the course of the last decade, with tensions stemming from an ageing population, the increasing prevalence of chronic diseases and the rising cost of healthcare technology and products.

The organisation and governance of healthcare systems have also undergone profound transformations, which have particularly affected the relationships between central and local authorities.

It thus appears useful to conduct a first assessment of these changes to put our country in context relative to its neighbours and to take the full measure of the reforms and experiments carried out.

In 2015, the Cour des comptes studied the health insurance systems in France and Germany2. However, it had never conducted a comparative investigation of healthcare and healthcare insurance systems in a large set of European countries to which France can be usefully compared.

[1] For the 23 principal countries of the European Union for which statistics are tracked by the Organisation for Economic Co-operation and Development (OECD), 2015 data.

[2] Cour des comptes, *Report on the implementation of social security finance acts*, *September 2015*, Chapter XV Pension systems in France and Germany, p. 533-588, La Documentation française, available at www.ccomptes.fr.

This was the purpose of the enquiry it carried out[3], which traces the responses of other European countries to the growing but unequal tensions to which their healthcare systems have been subjected for the last 10 years (I) and the structural reforms which they implemented (II).

I - Growing but uneven tensions on healthcare insurance systems

While all countries in Europe were affected by the 2008-2009 economic recession, only some of them had to face a crisis of their sovereign debt. Those nations implemented large-scale measures to limit socialised healthcare expenditures, which lead to a deterioration in the coverage of healthcare demand. The other countries also intervened to influence spending, but in less pronounced or lasting ways. Meanwhile, France preserved its healthcare and healthcare insurance system, at the cost of a persistent deficit in healthcare insurance.

A - Measures to limit spending varied in intensity by country

All European countries have implemented measures whose intensity varied according to the soundness of their public finances, with the aim of reducing the socialised portion of healthcare expenses, pay for medical professionals and investments. Moreover, all exert pressure specifically on drug expenses. The change in socialised healthcare spending per capita diverges between northern and southern Europe.

[3] The research was conducted between November 2017 and March 2018 and relied on available international document sources (in particular consultation of the harmonised health expenditures databases of the World Health Organisation, the Organisation for Economic Co-operation and Development and Eurostat) and French, German, English, Italian, Spanish, Dutch, Swedish, Portuguese and Irish documentation, as well as on a series of interviews made possible by the embassies of France with the main actors in the capital cities concerned (except The Hague), supplemented in Italy and Spain at the regional level (Latium and Tuscany; Castile, León and Basque Country).

1 - Deep cuts to salaries and investments and more expenses shifted to patients in countries most affected by the 2008 crisis

a) Growth in patient contributions to the cost of treatment

Nearly all the cost-saving plans involved increases in deductibles from reimbursements or co-payments or shifted certain expenses to patients.

These measures were at the largest scale in the countries most affected by the crisis, starting with Ireland and Portugal, which were targeted by the memorandum procedure with the European Commission, the European Central Bank and the International Monetary Fund after their sovereign debt crises. In Ireland, flat-rate contributions have been required since 2012 for hospital stays (€75 per day limited to 10 days, then raised to €80 in 2013), including accident and emergency services (€100). The monthly cap on prescribed medical goods and services to be paid by patients was set at €100 in 2009 and rose gradually to reach €144 in 2013. In Portugal, the flat rate co-payments for hospitalisation nearly doubled in 2012. Although they ranged from €3 to €10 depending on the type of treatment, the high end of the spread was increased from €10 to €20. In addition, deductibles from reimbursements were raised significantly for ambulatory care and reached high levels for certain drug categories (antidepressants, antacids and acetaminophen in particular).

Spain and Italy took the same course of action. In 2012, the former increased co-payments for drugs to as much as 60% for patients in the highest income brackets[4]; the latter introduced co-payments of €10 to see physician specialists, which came on top of a base payment ranging up to €36.15. Furthermore, an own contribution of €25 is also required for visits to accident and emergency services deemed not to relate to genuine emergencies.

In these four countries, extensive mechanisms were put in place to exempt or mitigate the impact of the measures adopted, which limited their on the most vulnerable populations[5].

[4] Nevertheless, deductibles from reimbursements are capped (at €8.14 per month for households whose annual income is less than €18,000, €18.32 per month for household income between €18,000 and €100,000, and €61.08 per month for higher incomes) and some segments of the population (tax-exempt retirees, job seekers who have exhausted their unemployment benefits, people receiving certain integration benefits) are exempted.

[5] For example, these mechanisms assisted 30% of the Irish population ('medical card' holders) and more than 50% of the Portuguese.

Though to a lesser extent, the levels of healthcare insurance were also reduced in other countries in the sample group studied. In the Netherlands and Sweden, where there are 'healthcare shield' mechanisms which, below a certain threshold, assign some expenses to patients, that threshold was progressively increased from €150 per year in 2009 to €385 in 2017 for the Netherlands and, more modestly, from approximately €90 to €110 in 2012 in Sweden[6].

In Germany, however, where an income-dependent 'healthcare shield' is implemented since 2004, along with a series of patient contributions to the cost of their treatment, in 2012 the €10 co-payments toward appointments with general practitioners and specialists were eliminated in light of the sound financial standing of the healthcare insurance system.

b) The shrinking of the healthcare basket

Several countries removed products and services from the basket of healthcare treatments covered. For example, in 2012 Spain began pursuing revisions aimed at eliminating treatments for 'minor symptoms' (over 1,000 products). Italy embarked on a similar initiative over the same period. Beginning in 2009, the Netherlands gradually refused to reimburse sleeping pills and tranquillizers in general cases, antidepressants, antacids, acetylcysteines[7], statins outside the application of recommended best practices, contraceptives for women over the age of 21, walking assist devices, anti-allergy coverage and certain long-term treatments[8].

The trend to concentrate public health spending on hospitalisation, general and specialised medicine, emergencies and the most important drugs while leaving patients to pay for most dental, vision, hearing aid and non-emergency healthcare transport expenses had nearly run its course in Germany, Italy and Spain, but it went on in the Netherlands and Ireland. Over the same period, France has not taken any action to restrict the scope of the healthcare basket covered by healthcare insurance.

[6] From 1,800 SEK to 2,200 SEK for prescriptions.
[7] Thinning agent used to treat respiratory illnesses.
[8] Psychological counselling, in-home care beyond 10 hours per week.

c) Reductions in size and pay of the medical professional workforce

In this realm, the gap between the measures taken by the countries most affected by the crisis and the others was especially pronounced.

The cuts were more severe in the countries where medical professionals, including physicians, are employed by a national healthcare system (Ireland, Spain, Portugal) or are contractually bound to it (United Kingdom, Italy), relative to countries with private practice systems (Germany, Netherlands). In Ireland and Portugal, the two countries under memoranda, the decreases in remuneration surpassed 30% for some categories of medical professionals in the former and reached 15% in the latter, combined, in the case of Portugal, with a five-hour lengthening of the workweek and a decrease in overtime rates.

Similar measures were adopted in Spain[9]. In Italy, the central government froze remunerations, capped payroll expenses for the regions and opted not to replace retiring personnel. In the regions with the greatest budget struggles, the medical workforce was drastically reduced[10].

The other countries took less severe measures. In the United Kingdom, however, there were freezes, then periods of wage moderation between 2011 and 2014, in addition to workforce reductions. In the Netherlands, the decentralised nature of the healthcare system[11] did not lend itself to widespread measures. Still, in 2008 a contribution system linked to healthcare provider revenues was put in place to mitigate the rise in healthcare expenses, and was replaced in 2011 by spending limit targets[12]. In Germany, for two years (2011-2012) legislative provisions blocked any changes in the pay of physicians, but catch-up raises were negotiated later. Nevertheless, the setting of ceilings for ambulatory care expenditures, combined with a third-party payer system (the healthcare insurance system), made it possible to contain the rise in the expenditures and income of privately practising physicians.

[9] Salaries were trimmed 5% for all public employees in 2010 (in this national healthcare system, medical professionals are employees of the state and autonomous communities) and the 14th month was abolished in 2012. The workweek was increased by 2.5 hours and leave time and paid sick leave were decreased. Headcounts also fell.

[10] A 15% reduction between 2006 and 2014 in Latium, for example.

[11] Competition between private insurances in a market that contracted, contracts between doctors in private practice and private insurances, a vast majority of not-for-profit hospitals.

[12] Agreed limits with specialists, then with all primary healthcare providers, to hold the increases in expenditures to 2.5% per year.

d) Decreases in investments

Here again there were marked divergences: the statistics on gross fixed capital formation in the healthcare sector (buildings, equipment) gathered by the OECD or national sources show stability or growth for Sweden, but extremely steep drops for Spain (up to 60%, as it tumbled from €2.7 billion in 2008 to €1 billion in 2015), the United Kingdom, Ireland and Portugal.

2 - Specific pressure on drug expenditures and hospital purchasing in all countries

The burden of drug spending, which accounts for an average of 1.5% of GDP in the countries of the European Union, was partially shifted to patients everywhere.

In Italy and Portugal, overall spending caps were introduced. When the maximum values were reached, pharmaceutical companies had to reimburse all or part of the corresponding expenditure overage[13]. These mechanisms, which are also implemented in France[14], have a key role, especially in Italy, in controlling the global level of healthcare expenditures. Comparable provisions are in place in the United Kingdom, where companies voluntarily participate in them, and in Spain since 2015, where they are more limited in reach (they only pertain to autonomous communities and not to the pharmaceutical companies themselves and are purely incentivising in nature).

A strong emphasis has been put on the use of generic drugs and, more recently, biosimilar drugs[15]. In some countries, such as the United Kingdom and Germany, it accounts for more than 80% of prescriptions. The obligations imposed on physicians, aside from exceptions whose scope varies according to country, to write prescriptions using international drug names and on

[13] In Italy, the laboratories reimburse the full amount of cost overages for ambulatory care and half for those pertaining to hospitals (the regional authorities pay for the other half). The Portuguese mechanism has morphed into a tax on laboratories from which they may be exempted if they curb expenses and contribute to financial funds that benefit hospitals or ambulatory care.

[14] Through the setting by the legislature of a safeguard clause 'L' aimed at trimming the growth in company turnover earned from drugs paid for by healthcare insurance and a contribution 'W' for the turnover earned from drugs to treat hepatitis C. Cour des comptes, *Report on the implementation of social security finance acts, September 2017*, chapter VIII Drug pricing policies: significant results, lingering major challenges of efficiency and sustainability, a framework for action in dire need of rebalancing, p. 335-395, La Documentation française, available at www.ccomptes.fr.

[15] Biosimilar drugs are copies of biologic drugs, unlike generic drugs, which are copies of chemical drugs.

pharmacists to supply the least expensive drug, were the first vector of deployment. In addition, many countries are developing training initiatives, awareness campaigns, digital prescription assistance tools, systems to monitor doctors' prescriptions to evaluate their performance in this area, as well as financial incentives[16].

To boost the efficiency of these measures, the prices of generic drugs have also been curtailed. For example, Spain defines reference prices based upon the lowest values of the molecules used in a given category of efficacy. Portugal, like France, requires a 60% decrease versus the cost of the original drug and Sweden requires a 65% discount.

Moreover, Sweden has also focused on competition among suppliers to lower costs by organising auction-style procurements by the Drug Agency. Along with the Netherlands, it can pride itself on obtaining the lowest generic drug prices in Europe. The recourse to bundled purchasing through calls for tender to supply the whole hospital system, or even the entire healthcare system, has also spread in recent years in Italy, Spain and Portugal, at the central or regional level. These procedures have often been extended to some of the hospitals' other procurements.

In order to control the growing cost of pharmaceutical innovation, European countries have made changes to their price setting methods. The products covered by healthcare insurance have been targeted more finely, thanks in particular to the implementation of medical-economic analysis methods that compare drug costs and effectiveness. New drugs are increasingly monitored in real life to assess whether their actual efficacy justifies their price[17]. In some cases, certain particularly costly drugs have only been introduced gradually[18].

Nevertheless, the generalised practice of confidential discounts on drug prices creates a situation of asymetric information that hampers governments in their negotiations with the pharmaceutical companies by limiting their ability to compare prices to those achieved by their counterparts. This situation calls for the implementation of a system for grouped negotiations by all or some Member States of the European Union, including France[19].

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[16] The United Kingdom is using all these mechanisms, while Italy, Spain, Germany and the Netherlands have adopted some of them.

[17] A registry system managed by the Italian Drug Agency is used to monitor over 130 drugs.

[18] Especially in Italy, Spain and Portugal for hepatitis C treatments.

[19] Cour des comptes, *Report on the implementation of the social security finance acts, September 2017*, chapter VIII Drug pricing policies: significant results, lingering major challenges of efficiency and sustainability, a framework for action in dire need of rebalancing, p. 335-395, La Documentation française, available at www.ccomptes.fr.

3 - Significant divergences in changes in healthcare expenditures and their coverage

The cost-saving programmes undertaken in all the countries have exerted generalised pressure on healthcare expenditures. Their growth rates declined considerably in Europe, with a downward trend starting from 2009, slowing from +7.9% per year between 2007 and 2009 to +2.4% between 2009 and 2014. The proportion of healthcare expenses paid for by healthcare insurance made a steeper decrease (from +7.9% to +2.1%). Thus, the average share of healthcare expenses covered by healthcare insurance fell from 74.1% in 2007 to 73% in 2014.

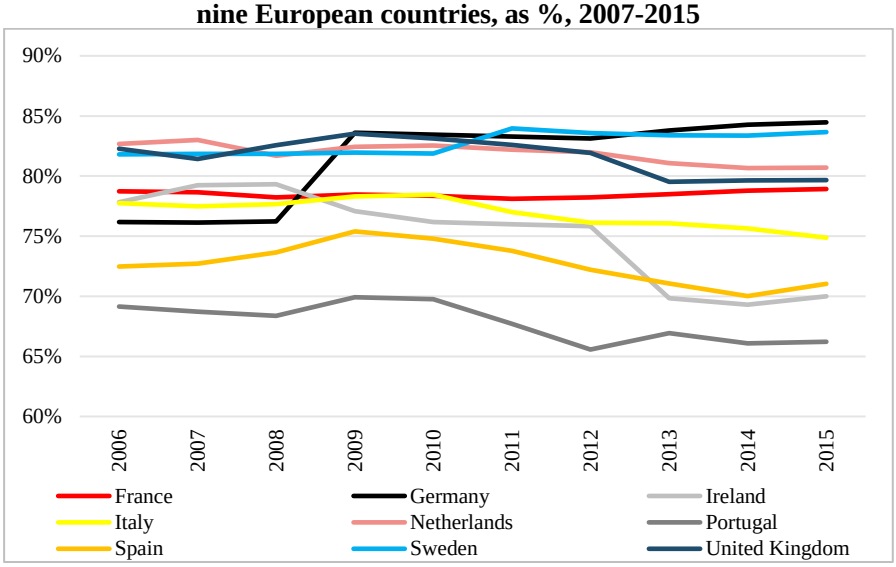
However, this slight (average) reduction in public spending on healthcare costs conceals widely varying national realities, linked in particular to the unevenly felt impacts of the 2008 financial crisis. Whereas Germany and Sweden were rather quick to restore their financial position and begin curtailing their debts, the Netherlands, the United Kingdom, Ireland and, above all, Italy, Spain and Portugal, went through a protracted period of often high deficits.

The effect of the crisis on France's GDP was comparable to the average of the eight countries studied over the entire decade elapsed, although the 2009 recession was less pronounced for France and the recovery in production was a bit slower starting from 2014. The public deficit in France was not lowered as much as elsewhere (in 2016, it was €42 billion, or 1.9 GDP point higher than the average public balances in the eight aforementioned countries) and, unlike the prevailing situation in most of the other Eurozone countries, public debt has still not begun to shrink relative to GDP.

Differing cost-reduction plans in distinct economic and financial contexts and financial resulted in a clear-cut divergence in public healthcare spending trends. While in Germany, Sweden, the Netherlands, the United Kingdom and France, public healthcare spending rose faster than the rest of public spending between 2007 and 2014[20], healthcare bore a more than proportional weight of the adjustments in Portugal, Ireland, Spain and Italy. In those four countries, the socialised portion of healthcare expenditures dropped.

[20] Public healthcare spending in Germany rose from 18.1% of all public spending in 2007 to 19.65% in 2014 (+1.6 point) and rose by nearly two points in the Netherlands over the same period, while public healthcare expenditures only accounted for 11.9% of government spending in Portugal (down 2.7 points from 2007) and 13.4% in Ireland (down 2.5 points) [World Health Organisation (WHO)].

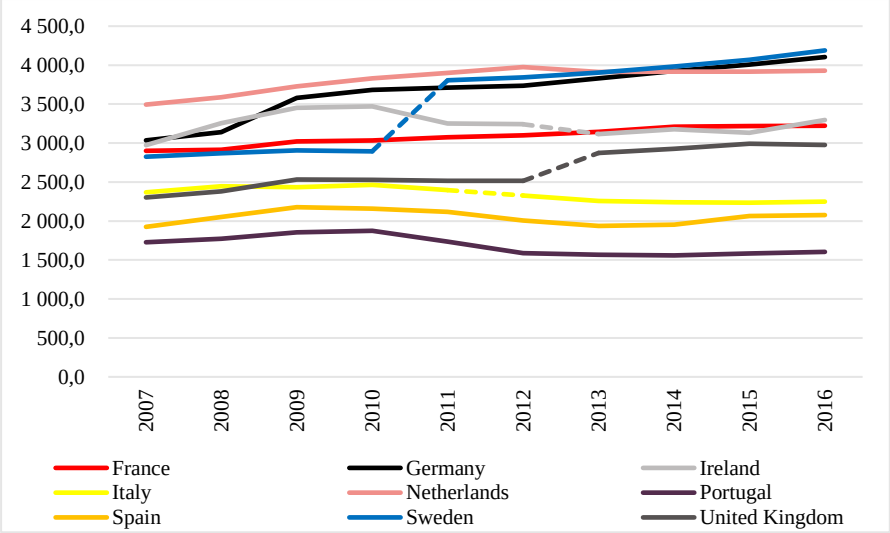
Graphic #1 : change in publicly funded portion of healthcare expenses in nine European countries, as %, 2007-2015



Source: OECD health database.

Measured in constant currency and purchasing power parity and disregarding the breaks in data series affecting some years, public spending per capita increased over the period in Germany, Sweden and the Netherlands and, to a lesser extent, in the United Kingdom and France. By contrast, it receded in Portugal, Ireland, Spain and Italy.

Graphic #2 : change in public healthcare spending per capita in nine European countries, in constant purchasing power parity, in constant USD, 2010 OECD base (2007-2016)



Note: the dotted lines indicate breaks in the series for Sweden in 2011, Italy in 2012, and the United Kingdom and Ireland in 2013.
Source: OECD health database.

These shifts resulted in a divergence in the changes in healthcare expenses to be paid by households: the patient burden rose sharply in Italy, Spain, Portugal and Ireland, as well as in the Netherlands[21], while it remained stable or even fell slightly in the other countries.

These developments were felt all the more by households because the additional expenses passed on to them were rarely covered by private insurance. While they grew significantly in Ireland, reaching 15% of healthcare spending in 2015 versus 8.2% in 2006, that was not the case elsewhere. In the United Kingdom[22], Spain and the Netherlands, the share of current healthcare expenditures paid for by private insurance has decreased since 2006, while remaining stable in Sweden[23]. Even in Italy, where the role of private insurance

[21] +2.9 points in healthcare spending in Italy and Portugal, +2 points in the Netherlands. and +1.5 point in Spain between 2006 and 2015; +2 points in Ireland between 2006 and 2012 according to the WHO database.
[22] In that country, 5.5% of healthcare spending and 11% of the population are now covered by private insurance purchased by employers or by individuals.
[23]United Kingdom: 5.5% of current healthcare expenditures in 2015 versus 7.2% in 2006; Spain: 4.7% versus 6.2%; Netherlands: 7.0% versus 8.1%; Sweden: 11.4% and 11.6%.

has more than doubled in 10 years, it is still not widespread (2.3% of expenditures)[24].

B - Perceptible negative impacts on some healthcare systems

Although it is still too early to assess the consequences on public health, in several European countries, the quantitative rationing of the provision of healthcare or the increased cost of access to healthcare has led to delays in treatments, or even, in some cases, to the suppression of a portion of healthcare demand.

1 - The consequences of the economic crisis on public health are yet unknown

An overview of the healthcare economics literature available[25] does not yet enable us to discern the impact of the economic recession on public health. On the contrary, there is a general indication that the economic difficulties experienced and, in particular, the rise in unemployment, are associated with a decrease in mortality. This apparent paradox may be explained by the positive effects on health of changes in behavioural habits pertaining to alcohol or tobacco consumption or driving (less driving leading to fewer road accidents) brought about by a decrease in income, which outweigh the negative impacts relating to reduced healthcare budgets.

[24] In Germany, the existence of a private system used by the wealthiest 10% of households is also attributable to their wish to get more generous benefits than those provided by the public system.

[25] In particular: *Economic crisis, health systems and health in Europe, impact and implications for policy*, Sarah Thomson, Josep Figueras, Tamas Evetovits, Matthew Jowett, Philippa Mladovsky, Anna Maresso, Jonathan Cylus, Marina, Karanikolos, Hans Kluge, *European observatory on health systems and policies*, 2015 and OECD Health Working paper n° 76, *Health, austerity and economic crisis: assessing the short-term impact in OECD countries*, September 2014.

Regarding the economic hardships endured since 2008, several studies have established correlations with some aspects of public health, starting with mental health[26] and the consumption of drugs that affect the nervous system, and with a drop in hospital stays and a greater frequency of obstetric problems[27]. However, it would be hasty to draw definitive conclusions from this handful of information.

First, most of the potential consequences of economic hardships are often felt well after their occurrence, which makes the case for a broader period of observation than what has been possible for health statisticians currently working to assess the effects of the 2008 crisis and of the reductions in healthcare spending, many of which were not implemented until 2011-2012.

Second, the results obtained from studies of previous crises may not be applicable. Indeed, none of those episodes had both the scale of the fluctuations of these last 10 years[28] and the characteristic of occurring in a context where the public's overall health was so dependent on government spending, because of the rise in chronic illnesses and medical progress that enables longer-term survival through costly treatments.

2 - Longer wait times

The turnaround times to access to certain types of healthcare grew longer during the crisis, especially in the hardest hit countries. The States which run national healthcare systems financed by limited contributions from the national budget were especially affected, but were not the only ones.

In Italy, while data about wait times is not reported to the national level, the difficulty in securing an appointment with a specialist, in obtaining a medical exam or in scheduling an hospitalisation is by far, along with cost, the top

[26] A study by the National Suicide Observatory, *Suicide: Knowledge review and possible avenues of research*, First report, Paris, 2014, reveals an increase in suicide among men of working age.

[27] These studies also highlight a drop in alcohol-related deaths (OECD and *European observatory on health systems and policies, op. cit.*).

[28] Although not comparable to the phenomena analysed in this chapter, the considerable public health impact of the collapse of the USSR (male life expectancy in Russia plummeted from 64 to 57 years old between 1991 and 1994) because of an increase in alcohol consumption, suicides, homicides and heart attacks, attests to the consequences of extreme disruptions (*The impact of macroeconomic conditions on health conditions, Nicolas Da Silva, in* The review of the Economic and social research institute, number 91-92, February 2018).

grievance shown by surveys about the national healthcare system[29]. In some cases, the only option available is to fall back on private appointments organised, via the *intramoenia* system, by hospital physicians in addition to their primary work, or to turn to the private sector, which is costly in Italy, especially since private insurance is not widespread.

In Portugal, the number of medical examinations decreased by one-fourth between 2010 and 2012 because of budget cuts and, at the start of 2018, more than 700,000 people were not registered as patients with any primary care physician, which leads, in particular, to a lag in scheduling appointments. The implementation of national statistics, however, makes it possible to partially monitor the situation[30] and measures have been taken to try to contain it[31]. In Ireland, waiting lists cover over 15% of the population[32]; the number of people waiting and the average wait times are on the rise. In the United Kingdom, the response times for some targeted services (surgery, cancer, ambulances, emergencies) have all deteriorated since 2012[33].

The situation in Spain has also worsened in some respects, albeit to a lesser extent. The number of patients on surgery wait lists rose 57% between 2006 and 2016[34]; the average wait time for surgery increased (83 days in 2016[35]), but has decreased for appointments (51 days at the time of writing[36]). In Sweden, wait lists are one of the factors contributing to the rise in private insurance, which enables faster access to healthcare.

3 - Growing inequalities

In some countries, regional disparities have worsened in the last decade. Such is the case in Italy, where the regional performance measurements taken by the Ministry of Health[37] show that the five regions that did not meet the minimum required levels in 2015 were all located in the southern half of the

[29] In particular, the survey of the consumer association '*Cittadinanzattiva* ' and that of the *Centro studi investimenti sociale* (CENSIS, 51th report, 2017).
[30] In 2016, the average wait time to see a specialist was 121 days. For surgery, it was 94 days.
[31] A reduced wait time program for appointments; all the country's hospitals have been joined into a network for some treatment types.
[32] According to statistics from the *National Treatment Purchase Fund*.
[33] According to a study by the *King's Fund*: *What is happening to the waiting times in the NHS?*, November 2017.
[34] +24% for appointments.
[35] Versus 70 days in 2006.
[36] 29 days in 2006.
[37] A set of 166 indicators covering the activities, results and hospital segment of the healthcare system, which notably include measurements of 30-day and one-year mortality rates after certain medical procedures.

country. The gaps between the regions have widened since 2002, feeding a phenomenon in which patients are migrating from the south to the north of the peninsula. In Portugal and Spain, disparities are often more pronounced between the most landlocked areas of the interior and coastal zones.

Sample surveys coordinated by Eurostat on the non-use of healthcare highlight a distinct rise in the perception of unmet needs. Indeed, for all reasons combined, these rose from 2.4% of respondents for the entire population of the European Union in 2008 to 3.2% in 2014, before returning to their pre-crisis level in 2016. Although these unmet needs are self--reported from people in vastly different national contexts and are thus difficult to compare, an examination of the responses by country shows that, with the notable exception of Spain, the expression of unmet needs was highest in the countries most deeply affected by the economic crisis. The gap between the highest and lowest income quintiles also widened during the period of the most severe budget restrictions, shifting from approximately 1 to 4 in 2008 to 1 to 5 in 2014.

C - In France, a focus on preserving the system, at the cost of persistent deficits

Compared to the European countries most affected by the crisis, France succeeded in preserving the socialised portion of healthcare expenses, broad access to healthcare and the size and earnings of the medical workforce. Despite having better managed the overall rise in healthcare insurance expenditures than in the 2000s, the corollary to these choices was the persistence of large deficits, both before and after the 2009 economic recession.

1 - Portion of socialised expenditures kept at a high level

France was less affected than other European countries, especially the ones that had to implement substantial cost-saving plans, and it made more limited use of deductibles from reimbursements, co-payments and flat-rate fees to be paid by patients. Between 2007 and 2011, these mechanisms lowered the amount of medical insurance expenditures by nearly €2 billion, or approximately 1% of total consumption of medical goods and services[38]. Since then, the social security finance act for 2018 raised the hospital fixed price, thus

[38] Cour des comptes, *Report on the implementation of the social security finance acts, September 2016*, Chapter IV: Insured party contributions to funding their healthcare expenses: a growing burden, a need to redefine medical coverage, p.153-203, La Documentation française, available at www.ccomptes.fr.

shifting €200 million in spending to private supplemental insurance policies or directly to the minority of patients who do not buy this type of insurance.

Similarly, a greater share of drug expenses were passed on to private supplemental insurance companies or directly to patients: in 2011, introduction of a reduced rate of reimbursement (15%) by healthcare insurance of drugs with low medical benefit and reduced rate of reimbursement for drugs of medium medical benefit (from 35% to 30%); termination of the reimbursement of drugs of low medical benefit in 2011, 2012 and 2015.

In addition, over the last 10 years there has been a rise in occurrence of overages in professional fees beyond the rates covered by healthcare insurance, a particularity in our country – even among those with a healthcare insurance system[39] – although the average rate of overages has fallen off slightly since 2013[40].

Despite this combination of developments leading to a deterioration in people's coverage, the overall rate of health expenditures paid for by healthcare insurance held steady at a high level (78.9% of current healthcare expenses in the international sense in 2015 versus 78.7% in 2007, after reaching a low point of 78.1% in 2011 according to the Ministry of Health). This seemingly paradox is explained by the growing proportion in total expenditures of those related to chronic diseases which are 100% covered by healthcare insurance. Thus, in parallel, there is a growing concentration of healthcare insurance expenditures on patients affected by chronic diseases.

Moreover, while many countries have concentrated government-funded coverage on basic care, increasingly leaving patients or voluntary insurance schemes to cover dental and vision care in particular, France has taken a different tack. It has chosen to extend private supplemental health insurance to the entire population so that it covers these types of expenditures.

As a result, more than 95% of France's population is covered by supplemental health coverage: private supplemental health insurance for workers that is now compulsory for companies[41] and subsidised through tax and social security contributions' loopholes, means-tested public assistance for the

[39] In Germany, the higher fees for ambulatory care for those covered by private insurance (namely 10% of the population) has a different impact because the patients in question are covered exclusively by those insurers.

[40] Cour des comptes, *Thematic public report*, The future of healthcare insurance: ensuring the efficiency of spending and empowering actors, November 2017, La Documentation française, available at www.ccomptes.fr.

[41] Since 2016, all entities must provide a minimum package of private supplemental insurance for their employees and co-pay at least 50% of the coverage purchased, regardless of the level.

most disadvantaged – who are usually inactive[42], and individual insurance. In practice, the average rate of co-payment by French households in 2015 was 6.8% of current healthcare expenses, the lowest rate in Europe. Furthermore, it has decreased: in 2007, the figure was 7.4 %.

Nevertheless, this average encompasses individual situations which vary according to the existence and level of private supplemental health insurance, as well as the nature of the expenditures. The expenditures to be paid by households frequently pertain to dentures, hearing aids and vision correction. To prevent the non-use of these medical devices, the government authorities worked with the health professionals concerned to define compulsory medical insurance and supplemental medical insurance and offers with no co-payment after the application of these two levels of coverage. These will be implemented between 2019 and 2021[43].

2 - A healthcare system beset by less tension than in other countries

Despite the numerous weaknesses in the organisation of the French healthcare system, which are regularly underlined by the Cour des comptes, the ongoing high level of investment[44], the continuing coverage of medical innovation and the persistence (except in 'healthcare deserts') of a relatively high density of healthcare professionals converge to rate France rather favourably in international comparisons. The same applies to life expectancy, ischemic heart disease mortality and survival after acute myocardial infarction or certain cancers[45].

According to opinion surveys coordinated by Eurostat, the French people's perception of healthcare accessibility falls between the most pessimistic countries (Italy, Portugal, Ireland, Sweden) and those who feel their situation is the most advantageous (Germany, Spain, Netherlands, United Kingdom). Unlike the situation which prevail in Europe on the whole, the plight of the least well-off, according to these surveys, did not worsen as fast during the most

[42] Supplemental universal coverage ('CMU-C') that is free of charge for its beneficiaries and financial assistance to pay for private supplemental health insurance ('ACS') granted to households whose income exceeds the CMU-C income cap.
[43] See Chapter VII of this report: Vision care: a need to reorganise coverage, p. 241.
[44] Gross fixed capital formation for all actors in the healthcare system rose from €12.8 billion in 2008 (or 0.64% of GDP) to €13.2 billion in 2015 (or 0.6% of GDP), after a high point of €14.1 billion in 2011 (0.68% of GDP). This reduction reflects the completion of the 'Hôpital 2012' investment plan.
[45] Cour des comptes, *Thematic public report*, The future of healthcare insurance: ensuring the efficiency of spending and empowering actors, November 2017, La Documentation française, available at www.ccomptes.fr.

difficult years of the crisis. It has even bridged the gap with the most well-off insured people in recent years.

Table #1 :reported needs for medical examination or treatment that were not met for the sole reason of their cost, by income bracket (age 16 and up, 2008-2016)

	2008	2009	2010	2011	2012	2013	2014	2015	2016
20% of the population with the highest incomes	0.1	0.3	0.3	0.4	0.2	0.4	0.5	0.1	0.2
20% of the population with the lowest incomes	4.1	4.2	4.8	5.2	4.9	5.0	6.3	2.3	3.0
Gap	4.0	3.9	4.5	4.8	4.7	4.6	5.8	2.2	2.8

Source: Eurostat.

3 - Favourable trade-offs for healthcare professionals

The size of the workforce continued to grow for both physicians (224,875 for all modes of practice combined at 1st January 2017, or +4% since 2008[46]) and those employed by the public hospital sector (1.044 million at the end of 2015, or +3.9% since 2010[47]).

Savings measures of limited scope were applied to the salaries of healthcare professionals. For the most part, they were directed towards the staff of public healthcare institutions and those in private practice were hardly affected.

The freeze from 2010 to 2015, then again in 2018, on the value of the index point for civil service applied to public hospital personnel. Beyond the generalised raises in the index point in 2016 and 2017, some benefited from sector overhaul measures (the PPCR, or Professional Pathways, Careers and Remuneration protocol which applies to all three categories of civil servants), whose implementation was delayed by one year and has been stretched out over four years (from 2018 to 2021).

[46] Healthcare overview, DREES (Directorate for research, studies and the assessment of statistics).
[47] Statistical series from the DGAFP (General directorate for administration and civil service).

Between 2011 and 2017, the lack of any increase to the prices of medical consultations positioned France below the efforts made by some of its neighbours. It did not prevent the remuneration of privately practising physicians from continuing to grow at a fast rate[48], owing to the rise in 'non-letter' remuneration (technical medical procedures rate chart, remuneration according to public health goals), the increased volume of medical and paramedical procedures – which are insufficiently regulated – and the ongoing increases in fee overages measured in absolute value. Since then, the 2016 agreement between Healthcare insurance and physicians has provided for many revaluation measures, including an increase from €23 to €25 in the basic rate of medical consultations ('letter C'), for a total full-year cost estimated at €1.25 billion, including the portion not financed by Healthcare insurance and primarily concentrated over 2017 and 2018.

In Germany, after freezes in 2011 and 2012, the doctor remuneration began rising again[49]. However, the context in which this growth took place differs widely from that of France: Germany has enjoyed virtually constant surpluses in healthcare insurance since 2004.

4 - A gradual return to financial balance in medical insurance, enabled above all by increased contributions

The cost-saving measures put in place in France did not suffice to deal with the spontaneous rise in expenditures.

There was already a large healthcare insurance deficit before the economic recession of 2009 (€4.4 billion in 2008). It surged to €11.9 billion in 2010. It began falling in 2011, owing primarily to increases in contributions totalling €11 billion between 2009 and 2016, and to a lesser extent thanks to increasingly effective regulation in spending[50], whose official growth rate was brought down from 4% in 2007 to 2.2% in 2017[51].

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[48] Cour des comptes, *Report on the implementation of the social security finance acts, September 2017,* Chapter V: Specialised private practice: containing growth in expenditures, improving access to treatment, p.213-256, La Documentation française, available at www.ccomptes.fr.

[49] +1.0% in 2013, +1.3% in 2014, +1.4% in 2015, +1.6% in 2016, +0.9% in 2017, +1.2% in 2018 (Federal union of health insurance funds, *KBV*).

[50] In particular in the framework of the 'ONDAM plan' which implemented numerous cost saving measures over a multi-year period.

[51] Effective growth rate in the national health insurance spending target (ONDAM).

These relative and recent successes should be analysed more precisely[52]. First, the social security finance act for 2018 raised the projected increase in healthcare insurance expenditures to 2.3% for each year between 2018 and 2021. Second, presentation biases conceal a faster rate of growth in expenditures. Finally, and most importantly, the mechanisms put in place to contain the overall rise of expenditures are starting to run out of steam. Except for drugs, expenditures relating to ambulatory care continue to rise at a rate of nearly 4% per year and their recurring overruns have to be offset during the year by reducing allocations of funds for healthcare and medico-social institutions. In 2017, a new difficulty reared its head: the increased activity of public hospitals was not enough to compensate for the impact on revenue of their rate decreases; their aggregate deficit almost doubled compared to 2016, swelling from €439 m to €835 m.

II - Implementation of structural reforms to improve the efficiency of healthcare systems

The European countries included in the scope of comparison carried out by the Cour des comptes successfully implemented often large-scale reforms aiming to more effectively control healthcare expenditures and to improve their efficiency over the long term. By contrast, the provision of healthcare in France underwent changes that are more limited in scope.

A - Deep changes in the organisation of the provision of healthcare

Alongside the income and expense measures taken to rebalance the public accounts in the short term, most European countries undertook or intensified structural changes aimed at improving improve the ratio of services provided by the healthcare system and the resources spent on them.

[52] See Chapter II of this report: The national health insurance spending target: weak construction and execution, p. 65.

1 - Revisions in methods of remuneration

The structural reforms implemented pertained first to the methods of remuneration of healthcare system actors, doctors and hospitals. As regards ambulatory care, changes in the method of remuneration of physicians was a powerful tool in most countries to improve the efficiency of the healthcare system. For example, in the United Kingdom, the remuneration of general practitioners comprises a flat sum per patient (capitation) to which various bonuses are added, including a so-called 'excellence' bonus which aims to motivate doctors to perform medical procedures defined as priorities by the National Health System - NHS (prevention, treatment of some pathologies). The same type of mechanisms are also applied in Sweden and Italy for general practitioners in relation to their attainment of public health goals.

Financial incentives, or even obligations as in Spain, were also used to incite doctors to practice in less densely populated areas. While the countries most affected by these measures (Sweden, United Kingdom) are those most vulnerable to 'healthcare deserts' owing to their geography, Germany also instated mechanisms to prohibit physicians from settling in over-served areas. In addition, some countries introduced incentives to take care of patients whose employment status is a threat to their health. Thus, the NHS weighted the capitation system with a coefficient linked to the employment status of the patients treated by each general practitioner.

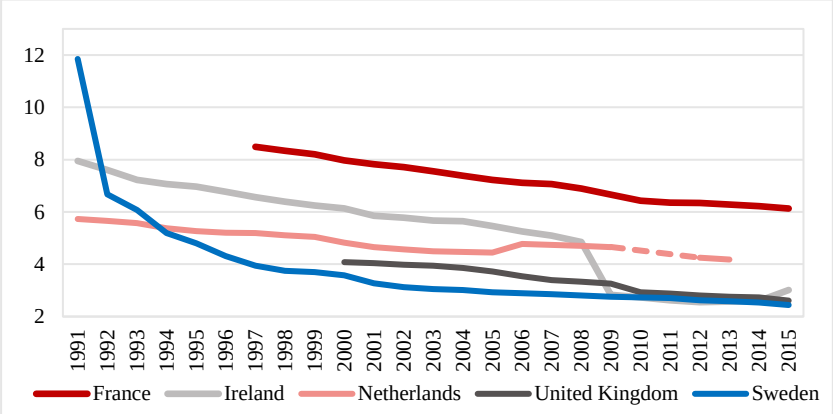
There were also profound changes to the financing of hospitals. Per-procedure pricing exists in most of the systems, where it is usually associated with global subsidies intended to cover certain types of expenses on a flat-rate basis. Such is the case in Italy, where this sort of financing compensates teaching, organ bank and transplant programmes managed by hospitals. The same applies in Portugal, where hospitals are compensated in the form of annual overall budgets (about half of which is by homogeneous group of patients and the remainder of which is by global flat rates or fixed rates linked to treatments). Also in Portugal, per-procedure payment for kidney dialysis was replaced by per-patient remuneration which covers not just the treatment itself, but also biological analyses, imaging and medicines prescribed for co-morbidities (anaemia, mineral deficiency, cardiovascular diseases).

Some countries, such as Portugal and Sweden, have added a layer of remuneration linked to the quality of treatment, assessed not just by adherence to procedures, but also by the results achieved.

2 - Overhauling hospitals

The reorganisation of hospitals was the second major component of the structural reforms implemented in other European countries. To improve the efficiency of healthcare expenditures, most countries reduced their hospital capacities and transferred some of these activities to the ambulatory care sector in pursuit of an 'ambulatory shift'.

Graphic #3 : change in the number of hospital beds for 1,000 inhabitants (1991-2015)



Note: the dotted lines indicate a break in data for the Netherlands in 2010 and 2011.
Source: OECD health database.

Some countries, like Sweden, which had experienced a major economic crisis in the 1990s, made this transition several decades ago; its number of hospital beds dropped from 12 per 1,000 inhabitants in 1991 to 2.4 in 2015[53]. In the United Kingdom, the number of hospital beds relative to the population was lowered from 4.1 for 1,000 inhabitants in 2000 to 2.6 in 2015. In other countries, reorganisation efforts were less pronounced: in Germany, this same statistic was 8 per 1,000 inhabitants in 2015.

The curtailment of hospital capacity was generally combined with a hospital grouping policy to improve spending efficiency. Sweden was a forerunner in this field: it created hospital groups in the 1990s. Each of Sweden's 20 regions has a hospital organisation divided into three levels: a university hospital to handle teaching, research and specialised care; multidisciplinary regional hospital centres; and primary care treatment centres. In each of these groups, the university hospital complex coordinates the provisioning of

[53] OECD data.

healthcare: it has authority over the other institutions in its geographical area. The Swedish model was adopted in Ireland starting from 2013. The 49 existing hospitals were arranged into seven hospital groups, each of them revolving around a referring university hospital that has jurisdiction over the entire group with regards to budgets and recruitment.

Without going so far as to eliminate hospitals as separate legal entities, these new organisations, which amount to subsidiarisation, have made it possible to streamline the hospital care supply in a way that improves the cost-to-quality of care ratio and the suitability of investments. Italian authorities embarked on a similar policy by reshaping their hospital system to comprise three levels of institutions and introducing minimum activity thresholds (maternity, surgery).

In all countries, these changes were accompanied by an increase in the provision of healthcare by the private sector and greater competition between public and private providers.

Originally, all Swedish hospitals were public, but their privatisation began in the 2010s, with limited results to date (15% of establishments are private). In the United Kingdom, hospitals were opened up to competition in 2012, with new structures called 'clinical commissioning groups' [54] (CCGs) being entrusted with buying healthcare services from them. Meanwhile, Ireland tasked a public agency (*National Treatment Purchase Fund*) with purchasing services not just from all public and private Irish hospitals, but also from foreign hospitals in order to reduce wait times in the most saturated institutions.

The Netherlands took the competition concept even further with the reforms carried out in 2006 by setting up three healthcare markets: the first pertaining to the compulsory choice of a private insurer by insurees; the second covering the purchase of healthcare services from market operators by insurance companies; and the third involving the free selection of one's healthcare providers by insurees.

3 - Streamlined care pathways

In the United Kingdom, Ireland and Sweden, nurses are bearers of healthcare on the primary level (with an emergency phone number in Sweden, for example). In the Netherlands, nurses specialising in mental illness have been responsible since 2008 for patient treatment regimes. In that country, moreover, 75% of general practitioners employ nurse practitioners.

[54] Networks supervised by the NHS and comprised of doctors and others.

Moreover, mechanisms were put in place to encourage coordination among healthcare actors in treating certain pathologies. This is notably the case in Italy with the experimental 'therapeutic care pathways' created in the national plan for chronic diseases (September 2016). Within these pathways, grouped payments cover all of a patient's services, whether they are provided by a hospital or by the ambulatory care sector.

Other measures were taken to improve medical and social support for patients. In Sweden, for example, responsibility for this sector was transferred to municipalities, while the healthcare system is financed by the regions. To spur an adequate number of spots in medical-social support structures, municipalities have a maximum turnaround time to take on beneficiaries after they leave the hospital. If they are unable to comply with this goal, they must pay the hospital for the additional cost of prolonging the stay.

4 - Digital data leveraged to improve quality of care

The use of information technologies expanded significantly within the framework of digital prescription systems in a large number of European countries.

These systems were put in place in the 2000s in Sweden, in the early 2010s in the United Kingdom and in the last few years in Spain, Italy and Portugal. Thanks to their functional features, the data collected are used not just to monitor the activities of practitioners, but also to develop prescription assistance software to, for example, encourage the use of generic drugs. Such is the case in the United Kingdom, for example, where prescription assistance tools automatically suggest generic drugs. In all the countries that have implemented this kind of system, the prescription profiles that can be extracted from the database serve as a basis for discussion between health insurance entities and the doctors concerned, particularly regarding the relevance of the treatments prescribed and the use of generics.

The use of information technologies has also enabled the development of digital medical files in some countries. Implemented in Sweden and Italy in 2018, these files round up documentation relating to patients' clinical history. Thus, they are essential tools in streamlining care pathways and improving the adequacy of treatments.

Digital data also enhances the assessment of the quality of care and results achieved. Drawing on a long tradition of epidemiology (the first public statistics in this field date back to the 17th century), a Swedish specialised agency (*National Board of Health and Welfare*) collects and publishes health data by region and by healthcare institution. This is not just an instrument to track the performance of the healthcare system and a means of recording and sharing

information relevant to the quality of care, but also a way to stimulate healthcare providers, who can gauge their respective results.

B - Strengthening of oversight mechanisms

In most European countries, healthcare expense management mechanisms were made more robust in order to address the needs of the population and public finance correction targets.

1 - Growing consideration of the population's estimated needs in regional funds allocation

In countries with a national healthcare system financed by taxes and directly managed by the State, mechanisms have been defined and gradually refined so that the allocation of public funds to the territorial level takes into account, at least in part, the effective needs of the population and not just the existing medical supply.

In Italy, which regionalised the organisation of healthcare in 2001, a national fund gathers the tax resources assigned to fund the healthcare system and divides the corresponding resources among the regions based on a distribution formula that factors in the population weighted by age, gender and healthcare consumption profile. This distribution formula was recently modified to incorporate performance. In Portugal, the healthcare regions created in 1990 have specific influence on the allocation of resources for ambulatory care, based in particular on patient gender and age parameters and the prevalence of four chronic diseases. In Spain, where autonomous communities have extensive competence, there is no earmarked distribution for healthcare at the national level; instead, the national government allocates a global budget. Nevertheless, this allocation does take into account weighted demographic criteria (population, land area, dispersion, insularity, protected population, people over age 65, people under age 16) which reflect, to a certain extent, healthcare needs.

In Germany and in the Netherlands, where a group of competing health insurance entities cover treatment, centralised mechanisms to allocate the proceeds from contributions were implemented in 2009 and 2006, respectively. In the first country, calculations of the standard expense[55] associated with the population groups covered by the insurers govern this mechanism. Patient morbidity is also taken into account in the second country. These mechanisms aim to prevent the funds that have a higher share of sick or elderly insurees being at a disadvantage. In Germany, there are also regional allocation formulas for ambulatory care which factor in morbidity[56].

2 - Tensions between the autonomy of local actors and control by central authorities

a) A long-standing trend towards decentralisation

For some 20 years or more, healthcare management and organisation responsibilities have undergone a gradual shift to the local level in most European countries. This shift was a follow-up, as in Spain[57], Italy[58] and the United Kingdom[59], to reforms of the overall administrative organisation. However, in some cases it followed a rationale unique to the healthcare sector. For example, since the 1980s Sweden has entrusted the financing of services and investment to its counties, which can adjust them, within a legislative and regulatory framework defined at the national level. In England (see *above*) in 2012, a proactive reform was applied to the clinical commissioning groups (of which there are 211) in charge of purchasing healthcare for the entire population, which they cover under the aegis of a Care Quality Commission that controls adherence to service quality standards.

The same trend has led countries that have national healthcare systems to grant more and more autonomy to hospitals that had initially been strictly integrated into the national systems. This shift is not new in the United Kingdom and Sweden, but is more recent in Portugal and Italy. In those countries in particular, measures aimed at benchmarking the results of healthcare institutions have shed light on their respective performance.

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[55] That is, the average expense observed for a given pathology, assigned to the portfolio of insurees for each fund.
[56] Via a mechanism which sets an expenditures ceiling by physician.
[57] The transfer of the administration of local healthcare systems was completed in 2001.
[58] 2001 also, as seen in the previous discussions.
[59] In 1999.

b) Strengthening of controls by central authorities sometimes resulting in a re-concentration of management

Conversely, the need to successfully implement the savings plans has led to a tightening of the controls exercised by central authorities in certain countries where the healthcare organisation had been hitherto decentralised.

For example, in Italy, where regional healthcare services had accumulated high deficits (€6 billion in 2006), 'deficit elimination plans' were drawn up. These plans are triggered as soon as expenditures exceed revenue by more than 5%. They are backed by programs aimed at restoring financial balance that involve adjustments to recruitments and remunerations, as well as a reorganisation of the provision of healthcare and improvements to purchasing procedures. As a result, the regional healthcare administrations come under close control by the central government that appoints, for the duration of the plan, a commissioner with authority over the region. This scheme was highly successful from a financial standpoint: financial imbalances have been divided by six in 10 years[60].

Regional mechanisms to control debt and deficits were also put in place via constitutional and organic rules in Spain. These pertain to the whole of finances of autonomous communities and not specifically to their healthcare systems. However, incentives were adopted to influence their choices in this realm. Indeed, the liquidity fund for autonomous communities, which distributed more than €120 billion in aid between 2012 and 2016, only disburses its funds if certain measures to check the growth in drug expenses or to improve the efficiency of treatment have been implemented, which was the case in a majority of regions.

In recent years, this reinforced surveillance has also been applied to healthcare institutions. Thus, in Italy, 'deficit elimination plans' for hospitals, drawn by those pertaining to the regions, were implemented starting from 2015. In Portugal, the need for stricter control of expenditures led to a de facto reversal of the autonomy of these institutions, which must now obtain authorisation from the Ministries of Finance or Health before any recruitments. These centralising measures did not put an end to the chronic deficits in that country, which have already required two extraordinary bailouts[61]. In the United Kingdom as well, the NHS had to create a specialised central fund, the Transformation and Sustainability Fund, to rein in the financial imbalances of hospitals. This fund

[60] Moreover, this decline in deficits was accompanied in some regions by a reduction in payment times, a drop in debt and an improvement in health indicators.
[61] In 2012-2013, €1.83 billion; in 2017-2018, €1.4 billion.

injected additional resources in the amount of £1.6 billion in 2016-17 and 2017-18, but without a decrease in the number of hospitals with shortfalls.

C - Healthcare organisation in France underwent few of the reforms implemented elsewhere in Europe

Despite some progress (increase in coordinated activities, promotion of ambulatory care, creation of regional hospital groups, implementation of remuneration based on public health targets), the structural reforms implemented in France since the economic recession of 2008-2009 have been more limited in scope. They lag behind those of the other countries in four key areas.

1 - Less regulation of ambulatory care

Ambulatory care in France is subject to fewer regulatory measures than those implemented in the other European countries.

Unlike the United Kingdom or Sweden, the role of the general practitioner in the patient's care pathway has remained modest. Furthermore, in spite of the progress pertaining the implementation of a ROSP (remuneration based on public health goals) by the 2011 medical convention between health insurance and unions of doctors and further changes made to this mechanism by the 2016 medical convention[62], the physician remuneration system does not give them enough of a stake in the major public health objectives, including the prevention of chronic pathologies. Nor does it enough to involve them in a better division of patient pathways between ambulatory and hospital care. Yet when implemented in other European countries, such as Sweden and the United Kingdom, such incentives have led to genuine improvements in the efficiency of ambulatory care, although certain goals (especially the prevention of healthcare deserts) have not been met for lack of adequate financial incentives.

As shown in Sweden and in Ireland, these regulation efforts do not necessarily imply low doctor salaries. They are not in conflict with a certain degree of freedom of settlement for physicians (as, in the last two decades, Sweden and the United Kingdom have relinquished the principle of assigning an exclusive district to a doctor), nor with the patient's freedom to choose their

[62] See Chapter VI of this report: fighting cardio-neurovascular diseases: the case for prioritizing prevention and quality of care, p. 203.

physician. Indeed, in the United Kingdom, patients have been able to pick their general practitioners since 2015.

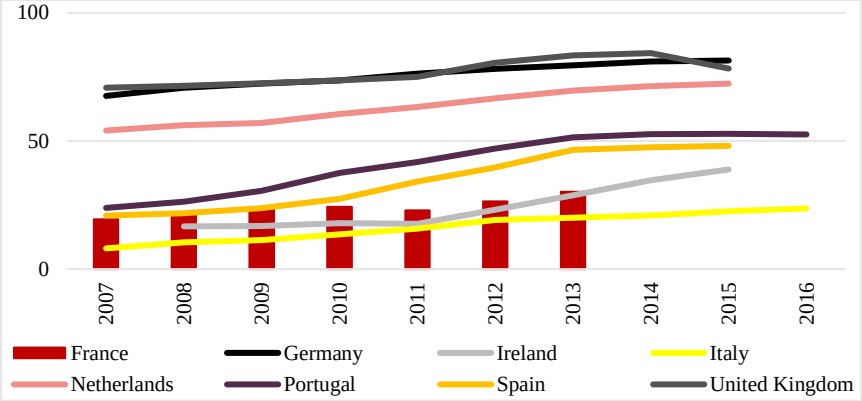
The French system of remuneration for physicians in private practice does not give them a stake in bringing the health insurance into financial balance. Yet such an approach is not impossible: for example, in 2003, Germany set out to correct certain excesses arising from per-procedure payment (increase in prescriptions, rise in number of consultations) by implementing a budget system (*Praxisbudget*) which caps the remuneration of each physician. Beyond a ceiling defined for each practitioner, their remuneration no longer increases, which encourages them not to further expand their operations. Such a scheme is facilitated in the German case by the existence of a third-party payer system as doctors are paid directly by the funds.

Finally, France has not set up an efficient mechanism to adjust the supply of healthcare to the health needs of the population. The significant discrepancies in ambulatory care consumption between areas with a strong supply of healthcare professionals and those without continue to widen. Attempts to prevent 'healthcare deserts', including financial incentives and the adjustments to freedom of choice in a practice location, have yet to yield any notable effects. The failure to organise ambulatory care leaves hospitals responsible for the care and cost of patients unable to find doctors because of long wait times, a reduction in the time slots set aside for unscheduled appointments or the lack of medical presence at night and during weekend and holidays.

2 - Still limited use of generic drugs

Concerning medicine expenditures, the use of generics is still low in France: the market share of these products is 36% by volume, which stands for than half the proportion in Germany and in the United Kingdom.

Graphic #4 : share of generic drugs by volume in the reimbursed medicines market in France, Germany, Ireland, Italy, Netherlands, Portugal, Spain, United Kingdom[63] (2007-2016, as %)



Source: OECD health database.

This situation stems from the relative ineffectiveness of the instruments put in place to regulate doctor prescriptions and to empower patients while, as previously mentioned, several measures to promote the use of generics have proven successful in other countries.

In this respect, the United Kingdom, which implemented a policy to boost the use of generic drugs several decades ago, is a model to be followed. The NHS uses several tools to this end: an effort to sensitise physicians during their initial training about the economic issues relating to healthcare; prescription assistance resources[64]; development by the NHS of an information system which makes it possible to get a better picture of the prescription habits of each doctor; the use of financial incentives which imply that a portion of physicians' remunerations depends on their prescription of generic drugs; a legal requirement for pharmacists to substitute generic drugs for comparable original drugs.

On the other hand, in France, the growth in generic drugs does not hinge on their prescription by doctors, but on their voluntary substitution by pharmacists. The latter are encouraged to do so by advantageous remuneration,

[63] Some countries and years are not available in the OECD database. Moreover, the units of measures are not the same for all countries: to assess drug consumption, France and Spain refer to the number of medicine boxes, whereas other countries track the daily dose.

[64] The PRODIGY (*Prescribing with Decision Support in General Practice Study*) software displays the generic substitutes in the physician's application whenever they prescribe a non-generic.

which is identical to what they would receive by selling the original drug, as well as a remuneration based on public health goals (ROSP) specific to their profession[65]. In this regard, the 2016 medical convention between health insurance and unions of doctors achieves a limited step forward in involving general practitioners in the prescription of generics by raising from two to four the ROSP indicators for targeted physicians for certain pathologies[66]. In addition, the 'directory of generic groups' that lists the original drugs and the generic drugs that can replace them has a restrictive scope. Meanwhile, Germany and the United Kingdom authorise substitution without any reference to such a directory[67].

3 - Still limited hospital reorganisation

Hospital changes lead to the same conclusions. France focused on decreasing prices without paying enough attention to reforming the hospital structures themselves, which have remained largely unchanged.

The law modernising our healthcare system (26 January 2016) did create territorial hospital groups. However, this development is minor compared to the reorganisations carried out in other countries, which were far more proactive in reshaping their hospital systems around university centres entrusted with the organisation of healthcare supply and a 'managerial' power over the institutions beneath them.

Therefore, while all public health institutions had to join a regional hospital group, the 135 existing regional hospital groups pool only specific support services and activities of the hospital institutions: regarding support services, information systems, purchases and health insurance billing, but not personnel or real property; in the realm of healthcare activities, only pharmacies, medical imaging and biological analyses. The powers of the director of the group's support institution are limited solely to the areas managed by that institution.

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[65] Cour des comptes, *Report on the implementation of social security finance acts, September 2017*, Chapter IX: The cost of drug distribution: a significant expense, improved efficiency required, p.397-443, La Documentation française, available at www.ccomptes.fr.

[66] Statins and antihypertensives and, following on the 2016 convention, asthma and urinary incontinence.

[67] Cour des comptes, *Report on the implementation of social security finance acts, September 2014*, Chapter IX: The distribution of generic medicines: overly poor results, high costs, p.257-289, La Documentation française, available at www.ccomptes.fr.

4 - Insufficient use of health data

Most opportunities arising from the digitisation of healthcare have yet to be seized. France has managed to collect massive volumes of health data, first in specialised databases, then in the national healthcare data system (SNDS) created by the Act to modernise the healthcare system of 26 January 2016, which is integrating these data[68]. However, those volumes of health data are still used to an insufficient extent. The same applies to the development of digital methods of healthcare coordination.

After the failure of the personal medical file[69], the generalisation of the shared medical file ('DMP') will not begin until the end of 2018 under conditions of effective inputting by healthcare professionals that call for close monitoring. As for digital prescriptions, today they are still at a preliminary experimental stage in a handful of 'départements'.

Once again, the situation differs from other European countries, which have embraced change at an earlier stage, especially Sweden and, to a lesser degree, Italy and the United Kingdom. The lack of digital prescription tools made available to physicians to prescribe drugs, medical devices and massage/physical therapy services causes frequent discrepancies between the products and services billed by the healthcare professionals concerned and what was actually prescribed, causing considerable financial losses to the health insurance system (some of which are of a fraudulent nature)[70].

CONCLUSION

Over the last 10 years, the European healthcare systems and healthcare insurance systems have responded in different ways to the economic crisis and to the imbalances in public finances that came with it.

To improve their financial position, the most affected countries had to take steep measures to cut services to patients, lower the salaries of healthcare

[68] To date, the SNDS includes the SNIIRAM ('National inter-scheme information system for medical insurance') managed by the CNAM; the PMSI ('Information systems medicalisation programme') of healthcare institutions managed by the ATIH; and the BCMD ('Cause of death medical database') managed by INSERM. Two other databases which are currently being created will be integrated in the SNDS: data from the bodies in charge of assessing disability and a sample of reimbursement data per beneficiary submitted by insurance companies.

[69] Cour des comptes, *Communication to the National Assembly's Finance standing Committee*, The cost of the personal medical file since its implementation, February 2013, La Documentation française, available at www.ccomptes.fr.

[70] Cour des comptes, *Report certifying the financial statements of the social security system for the 2017 accounting year*, May 2018, La Documentation française, available at www.ccomptes.fr.

professionals and increase their work time, reduce investments and scale back drug prices and hospital purchases. Conversely, those that succeeded the most in overcoming their economic difficulties were able to boost their healthcare expenditures, sometimes lowering household co-payments by phasing out deductibles from reimbursements and co-payments implemented earlier and raising the remuneration of practitioners.

In this context, France followed a specific approach. Unlike most comparable European countries, it chose to protect patients from cuts to the level of protection against healthcare risks. Largely, it also preserved the level of public coverage of healthcare expenditures for patients, the level of hospital investments and access to new medicines, as the size and remuneration of the healthcare workforce continued to grow.

However, these results were achieved at the cost of public deficits, which have remained at high levels for far longer than elsewhere in Europe, and of public debt that continues to rise relative to GDP. Moreover, these results are vulnerable due to the insufficient regulation of ambulatory care and the near-exhaustion of measures to contain hospital spending, whereas health expenditures are rising continuously owing to an ageing population, the growing scale of chronic illnesses and the rising cost of medical innovation.

Above all, a certain inertia has prevailed as regards structural changes to the healthcare system despite some progress, such as the collection of medico-economic data and the introduction of public health criteria in the pay of practitioners. Thus, France's trajectory and its ability to maintain its healthcare coverage system will be difficult to sustain in the long run.

Therefore, in light of these risks, the situation calls for structural reforms to reclaim some room for manoeuvre in the management and adjustment of the healthcare system, along the lines of what many European countries have done. The considerable gains in efficiency that they would yield, which the Cour des comptes regularly highlights, make it both necessary and possible to implement a strategy aimed at enhancing long-term efforts in this field. In the next three chapters, the Cour des comptes shall present several recommendations along these lines.